RapidSound, Inc / Green Valley Imaging
450 W Continental Rd
Green Valley, AZ 85622
520.625.7670

PLEASE PRINT

Name:_____ Date of Birth: _____/_____/_____
Doctors Name:_____
Have you ever been diagnosed with breast cancer? _____ If so, at what age?_____
Have you ever had ANY type of cancer? (please list type)_____

PREVIOUS BREAST TESTS:
Mammogram: Date: _____/_____/_____ Where? _____
Ultrasound: Date: _____/_____/_____ Where? _____
Last time your doctor examined your breasts? Date:_____ Do you regularly examine your breasts? _____

Do you have a family member with a history of **BREAST** or **OVARIAN** cancer? YES NO
Mother _____ Age at diagnosis_____ FATHER with breast cancer? _____
Sister _____ Age at diagnosis_____
Daughter _____ Age at diagnosis_____
Other:_____

Have **YOU** had any of the following?

Cyst drained:	YES / NO	Side _____ Year_____
Surgical Biopsy:	YES / NO	Side _____ Year_____
Lumpectomy for breast cancer:	YES / NO	Side _____ Year_____
Mastectomy:	YES / NO	Side _____ Year_____
Radiation for breast cancer:	YES / NO	Side _____ Year_____
Chemo for breast cancer:	YES / NO	Side _____ Year_____
Breast Implants:	YES / NO	Side _____ Year_____
Breast Reduction or lift:	YES / NO	Side _____ Year_____

Last menstrual period: _____ Any possibility of pregnancy? _____
Are you post menopausal (no period for at least a year)? _____
Are you currently taking hormones or birth control? (type) _____

Do you have any **NEW** breast problems? YES / NO (if yes please circle problem):

Lump Nipple Discharge Nipple changes New skin changes (dimpling)

TECHNOLOGIST USE ONLY

Tech: _____ Date: _____

Acct: G
Referring:

Bilateral Unilateral R / L

SCREEN DIAGNOSTIC